Healthy cities tackle the social determinants of inequities in health: a framework for action

World Health Organization
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Abstract

This report provides practical guidance for taking action to address health inequalities at the local level. It offers helpful explanations of key concepts and offers examples of how to go about making a case and deciding which interventions to use to tackle more effectively the social determinants of health and increase commitment to addressing the causes of inequalities. The framework for action supports whole-of-government and whole-of-society approaches. The main evidence underpinning this publication can be found in the complementary report: *Addressing the social determinants of health: the urban dimension and the role of local government.*

Keywords

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Foreword

Translating scientific evidence and policy recommendations into action can be challenging, especially when the aim is to convince, engage and mobilize several sectors and diverse stakeholders. The evidence on the social determinants of health and understanding of the root causes of inequities is very strong, and the imperative for action is higher on political agendas than ever.

The rapidly growing body of scientific evidence in this field has generated more awareness and legitimacy but also urgency for action. The European Healthy Cities movement has a longstanding commitment to tackling health inequalities. However, experience has demonstrated the need for guidance, tools and frameworks that can help decision-makers address these issues systematically.

This publication was developed to support cities in their efforts to generate sustainable commitment and action to address the social determinants of health and health inequalities. Above all, this document is meant to be practical and adaptable to different local circumstances and realities.

I would like to express my gratitude to Anna Ritsatakis, principal author of this publication, and to all the members of the WHO European Healthy Cities Network and European national healthy cities networks, which provided helpful feedback throughout the drafting process. A special thanks is also due to Joan Devlin for her valuable input.

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1. Introduction – purpose of the framework

The WHO European Healthy Cities Network remains constant to its founding values of promoting equity in health, social justice, sustainable development and ethical governance. For cities participating in Phase V of the WHO European Healthy Cities Network, the overarching theme is that of health and equity in health in all local policies *(1)*.

In joining Phase V, the cities in the WHO European Healthy Cities Network are aware of the need to implement the recommendations of the WHO Commission on Social Determinants of Health *(2)*. Since so many countries in the WHO European Region are members of or linked in some way to the European Union (EU), the EU health strategy for 2008–2013 *(3)* and the communication from the European Commission on reducing inequalities in health *(4)* are also important.

Consequently, the mission for 2009–2013 is defined as follows:

- The mission of the WHO European Healthy Cities Network during Phase V is to ensure that:
  - social and economic development in cities promotes equity in health;
  - all city departments, and the private sector, acknowledge their responsibility and accountability for promoting greater equity in health; and
  - action is taken across all sectors to work together to this end.

In a nutshell, this means tackling the social determinants of health inequalities, ensuring that health and health equity are protected and promoted in all local policies. During Phase V, as outlined in the Zagreb Declaration for Healthy Cities *(5)*, this mission is to be achieved mainly through the collaboration of cities on three core themes: (1) creating caring and supportive environments; (2) healthy living and (3) healthy urban environment and design.

An extensive report *(6)* has been prepared for the WHO European Healthy Cities Network that examines the implications for cities in the European Region of the evidence presented by the report on the Commission on Social Determinants of Health *(2)* and related work in countries. To complement the findings of that report, the WHO European Healthy Cities Network developed a framework for action in cities, highlighting possible points of intervention: how city governance and processes can more effectively tackle the social determinants of health and how capacity-building can ensure that these processes are sustainable.

The framework is intended as a resource document for the WHO European Healthy Cities Network, clarifying certain concepts and offering examples of actions cities might wish to try. These include tools and information available through the WHO European Healthy Cities Network or other WHO programmes and the expertise and experience of other cities. An attempt has been made to include examples from across the European Region. However, given the long history of recording inequalities in health in the United Kingdom and the relatively large number of cities from that country participating in the WHO European Healthy Cities Network, United Kingdom examples are overrepresented. As Phase V progresses, this will be rectified and further examples of action in cities across the European Region will be collected and made available on the web to promote and support implementation throughout the WHO European Network.

In using this framework, readers are advised to take particular note of sections with a blue background:

Such text will be bold with a blue background.

since this signifies either questions that cities need to answer as they assess their own stage of development and consider appropriate intervention points during Phase V of the WHO European Healthy Cities Network or messages of particular importance in tackling the social determinants of health in cities.

The concluding part of the framework (Section 6) brings these questions together to facilitate rapid self-assessment by cities.

2. Background to the development of the framework

Several important factors were taken into account in developing the framework.

- The WHO European Healthy Cities Network includes cities who joined in Phase I and have focused for more than 20 years on tackling inequalities in health; new member cities in which the concept of equity in health may be comparatively novel; and cities at various stages in between.
- It was therefore considered important to take advantage of the experience of older members while encouraging them to make further efforts and to share their successes and failures with newer members. The intention is to avoid reinventing any wheels but also to help bring fresh eyes to throw new light on old experience.
- The WHO European Healthy Cities Network and other WHO programmes and projects have developed a wealth of knowledge and tools related to promoting intersectoral action to tackle inequalities in health.
- Work during previous phases of the WHO European Healthy Cities Network includes the development of city health profiles, city health development programmes, healthy urban planning, health impact assessment, community engagement and capacity-building for each of these, all of which are closely related to tackling the social determinants of inequalities in health.

It was therefore understood that the framework for action should take into account work already carried out and be sufficiently practical to offer clear aims but also be sufficiently flexible to accommodate cities at various stages of tackling the social determinants of health and to which differing responsibilities may have been devolved from the national or regional level. The cities in the WHO European Healthy Cities Network differ widely, and this rich variety of experience must be taken into account while preparing a common journey.

Linked to this thinking was the notion that, in real life, city development rarely follows the seemingly neat, linear process of the classical policy cycle – awareness-building, policy formulation, implementation, monitoring and evaluation. In practice, policymaking is more chaotic. For example, external events at the international and national levels, changes in the political, economic and social climate, the presence or absence of local leaders and other factors all influence the strengths and weaknesses of cities in tackling the social determinants of health and the opening or closing of windows of opportunity for action.

This is accentuated by the fact that Phase V takes place during an unprecedented economic crisis. Partly fuelled by this crisis, there are signs of social unrest in parts of the European Region, and the impact of climate change looms over all. It is within the boundaries of this triple economic, social and environmental crisis that the challenges of the growing health gaps must be faced while searching for new opportunities to promote equity in health.

While outlining the general direction of joint efforts, the framework for action offers examples of how cities might go forward. It is intended as a smorgasbord in which cities select different entry points and pathways to reach common goals, depending on their local situation.

Three working groups discussed a first draft of this publication during the Annual Business and Techni-

cal Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in 2010. Based on the valuable comments and suggestions made by participants at the Conference, the original draft was rewritten and sent to healthy city coordinators for further consultation and then again revised. The revised framework was then presented in a plenary session of the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Liège, Belgium in 2011 and discussed in two teach-ins during the Conference. The purpose of the teach-ins was to ensure common understanding of how the framework is to be used in cities, to share information on progress and consider possible ways forward. Particular attention was given to discussing the three basic commitments of the framework (Section 6).

3. Why is a concerted effort needed now to tackle the social determinants of inequalities in health?

There are several answers to this question.

- There is evidence-based knowledge of the magnitude of the health gaps, what causes them and the type of action through which they could be tackled.
- Totally unacceptable inequalities in health have persisted over many years and continue to widen despite persistent efforts in some regions and cities.
- The present economic crisis could worsen the situation even further.
- Experience indicates that sporadic, single interventions simply do not work but that the intersectoral action necessary for a whole-of-local-government approach may be easier said than done.
- The question of how to focus on tackling the social determinants of health therefore needs to be rethought.

The WHO Constitution *(7)* states that everyone should enjoy a level of health that would enable them to lead a socially and economically productive life. Over 30 years have passed since the WHO Health for All policy *(8)* mobilized countries in the European Region to tackle inequalities in health. Despite continued efforts in some countries to tackle inequalities in health at the national, regional and local levels, the health gaps persist between countries, within countries and within cities.

In 2008, the greatest difference between countries across the European Region for life expectancy at birth was a shocking 19 years for males and 11 years for females. Across EU countries, the greatest differences were 14 and 8 years, respectively. There are unacceptable health gaps within countries. In England, for example *(9)*: “People living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods. Even more disturbing, the average difference in disability-free life expectancy is 17 years. So people in poorer areas not only die sooner, but they will spend more of their shorter lives with a disability.” There are similar gaps within cities.

In Malmö, Sweden, for example, people in some parts of the city live as much as eight years longer than those living in other parts of the city *(10)*. In the wealthiest part of London, a newborn male can expect to live 88 years; a few kilometres away in one of the poorer areas, male life expectancy is 71 years *(9)*. Even within disadvantaged groups in a city, the causes of inequalities in health may differ by sex and by age, as studies of women in Madrid *(11)* and adolescents in Barcelona *(12)* have shown, indicating the complexity of the issue.

The 2009 European Commission communication on reducing health inequalities *(4)* states: “While there is general agreement on the principle of reducing health inequalities, the level of awareness and the extent to which action is being taken varies substantially. Over half of the EU Member States do not place policy emphasis on reducing health inequalities, and there is a lack of comprehensive inter-sectoral strategies.”

In this respect, members of the WHO European Healthy Cities Network are perhaps in a more favourable position. In 2009, when political decision-makers from 63 cities participating in the WHO European Network were asked to rank the three most important reasons for taking action on health, inequalities and social justice were at the top of their list. They consid-

ered inequalities in urban health as being “fundamentally unacceptable” *(13)*.

There are no quick fixes to tackling inequalities in health; it takes time and perseverance. Nevertheless, “closing the gaps within a generation” requires doing things differently. Adapting the results of Margaret Whitehead’s work to the experience of countries so far *(14)*, about five levels of progress can be defined in the process of tackling inequalities in health:

- awareness of the problem;
- sustained research to monitor and evaluate inequalities in health;
- political commitment to tackle the gaps through intersectoral action;
- acceptance by all sectors of their responsibility and accountability for equity in health; and
- coordinated action across sectors, to close the gaps.

The international literature clearly shows that awareness of the issue has increased, and research to clarify the extent and causes of inequalities in health has greatly expanded and improved. Less attention has been given to assessing what works in closing the gaps. Action across sectors has been sporadic and, until recently, has tended to focus mainly on vulnerable groups using traditional means of intervention in health and welfare *(15)*. Attempts to tackle the social determinants of inequalities in health through consistent, coordinated action across all sectors are still much less apparent.

Further, health gaps persist even in the Scandinavian countries, where half a century of egalitarian policies has ensured that social and economic inequalities are comparatively low. In many affluent European countries, inequalities in health are already totally unacceptable and increasing in some cases.

The size of the public debt throughout most countries in the European Region indicates that public finances will be constrained for many years. There are already signs that measures being proposed to tackle the economic crisis could endanger the welfare safety net that has been built up over many years in the European Region. The focus on getting out of the present crisis could also stimulate misguided short-term action. For example, unemployment in the EU is approaching 10% and nearly one third of the people 25–64 years old have no or few formal qualifications, but experts warn that the growth in temporary and contracting working arrangements could make employers less likely to invest in upgrading skills.

This is clearly not only a serious ethical issue but also a serious economic issue. According to Mackenbach et al. *(16)*, “Inequalities-related losses to health account for 15% of the costs of social security systems and for 20% of the costs of health care systems in the European Union as a whole. It is important to emphasize that all these estimates represent yearly values, and that as long as health inequalities persist, these losses will continue to accumulate over the years.”

Business as usual is not an option. The equity in health and development arguments need to be put much more forcefully to avoid having the socioeconomic inequalities that create inequalities in health become even more entrenched and difficult to tackle. It is essential that steps be taken to minimize the potential negative effects on health of the present economic crisis.

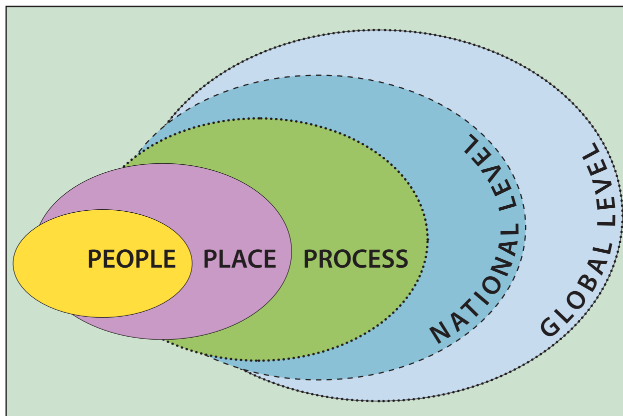
Wilkinson & Pickett *(17)* indicate that societies that are economically more equal perform comparatively better on a wide range of issues, from obesity, teenage pregnancy and mental health to levels of crime and imprisonment. They argue quite convincingly that equality is better for everyone.

The ongoing economic, social and environmental crisis may be the time to rethink the type of society to which cities could aspire. As governments, regional and local authorities struggle with difficult decisions affecting many of the social determinants of health, this could be a window of opportunity to tackle inequalities in health.

4. A reinvigorated approach to tackling the social determinants of health

City authorities are responsible for a particular place and for the health and well-being of the residents, migrants and visitors in that place (Fig. 1). City authorities operate within complex national and international policy frameworks over which they have little control. They have varying degrees of responsibility or potential to affect the processes occurring within the space for which they are responsible, such as administrative, regulatory, spatial planning, commercial and social processes. If the mission of reducing the health gaps is clearly defined and adopted, however, many of those processes could be reassessed in the light of attempting to close the gaps.

Fig. 1. People, place and process



Isolated, time-limited projects focused on various vulnerable groups will not bring about the shift in attitude needed to tackle the social determinants of health and inequalities in health. The aim must be to achieve progress at levels four and five outlined above, so that promoting equity in health becomes a societal goal tackled through systematic action in a whole-of-local-government approach. Just as the implications of actions on the environment are frequently considered, the potential effects of city development on inequalities in health and of inequalities in health on development must be considered.

4.1 People

The people living, working or passing through the city are the centre of concern as both the beneficiaries and creators of better health. Not only the people whose health appears to be most at risk but also the whole local community need to be considered. It also needs to be understood that achieving progress at levels four and five requires not only decision-makers in the health sector and other sectors being on board but also all those living and working in cities. This means:

> **Making the shift from intervening on a passive population to working with the city population to tackle the health gaps.**

For some cities, this requires a new approach to:

- how information about the population is compiled;
- the population groups on which to focus attention;
- assessing challenges and opportunities for decreasing the health gaps; and
- interacting with both social and professional groups to enhance social capital and create partnerships, making local people part of the solution.

4.1.1 Compiling essential information

Determining the major health issues requires access to data relating to lifestyles, behaviour, morbidity and

mortality, by small area, age, sex and socioeconomic variables such as income, occupation and education.

Comparatively few cities have such detailed data, and many would therefore have difficulty in reaching level two of the ladder of progress. Even cities that have sophisticated epidemiological data probably lack information on the local population's assets, referred to in more detail below.

Part of the problem is that the city is not responsible for collecting such data. In Denmark, for example, the regional level is responsible for compiling city-level data, and individual cities do not necessarily have the opportunity to decide on the type of information they would like available to inform policy-making. The cost of city-specific surveys is frequently beyond the reach of municipal authorities.

Working in the dark would not seem to be a reasonable option, however. All cities need at least to start compiling the essential evidence base, which can be improved over time. This may require lobbying national or regional statistical services for improved local-level data, perhaps applying pressure through associations of local authorities or encouraging local academics or nongovernmental organizations to take an interest. Using examples of cities fortunate enough to have access to sophisticated databases could add weight to such arguments. By whatever means this is achieved, the following are essential.

Regularly compiled data should reflect sex, age and socioeconomic variables such as income, education and occupation.

The knowledge needed to shift to an asset-based approach should be compiled and analysed.

4.1.2 Who should be targeted?

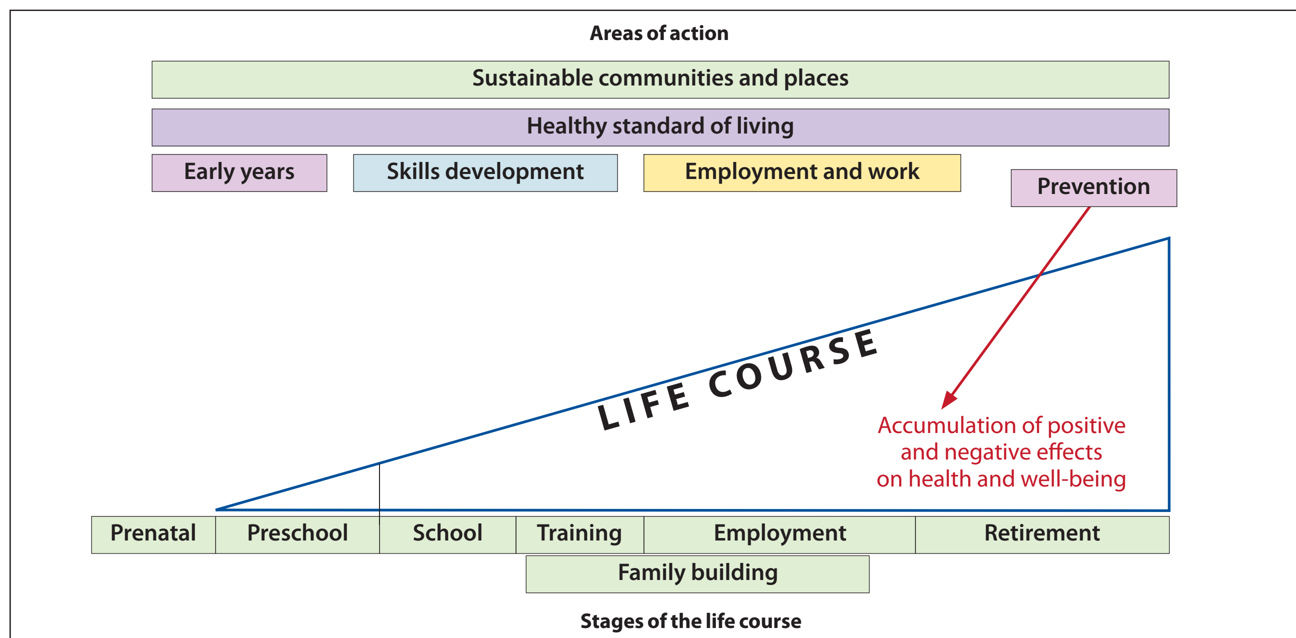
With some exceptions, past practice has focused interventions mainly on vulnerable or disadvantaged groups. The report of the Commission on Social Determinants of Health *(2)* recommends that attention quite rightly must be paid to the most vulnerable people, but covering the full gradient of inequalities in health is important. The report also recommends a life-course approach, with particular attention to young children.

Combining these two approaches means that, in considering the whole life course and specific stages of progress such as prenatal and early childhood health, moving from education to the workforce or the move into family life or retirement, extra attention should be focused on people in certain groups known to be at higher risk, such as people living in poverty, unemployed people, migrants and Roma.

The social determinants of health have different effects at different stages of the life course, and disadvantage, which starts even before birth, accumulates throughout life. *Fair society, healthy lives (9)*, the main report of the Marmot Review in England, indicates the areas of action for tackling the social determinants of health across the life course (Fig. 2). Dying with dignity might be added to this clear and useful diagram.

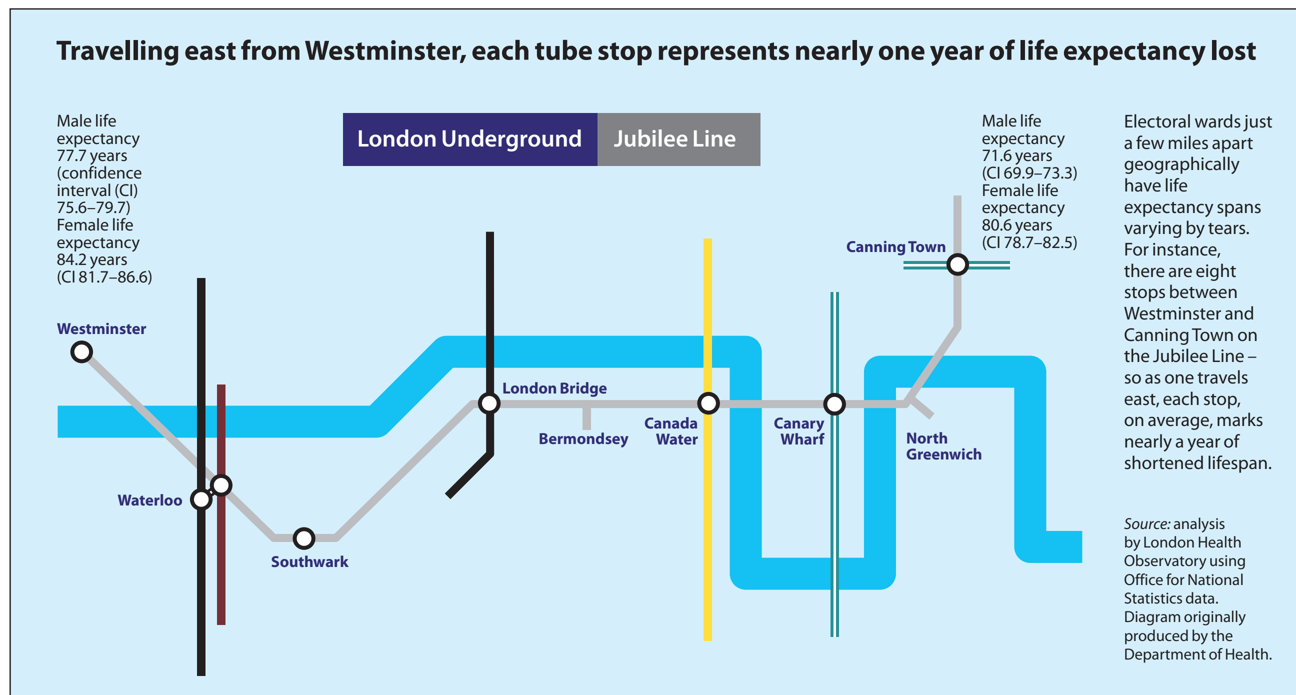
Action needs to be taken to support the most vulnerable people. The people at the bottom of the scale in relation to the distribution of power, money and resources and those who are marginalized or excluded need to be enabled to participate as fully as possible in economic and social life. For most health indicators, however, it is not simply a matter of the top versus the bottom. Moving from the highest to the lowest income, for example, the health indicators get worse with every step. Not only the people at the lowest end of the scale have poorer health than those at the top. As data from England indicate, whereas the gap in life expectancy between the areas with the highest and lowest income per person is 7 years, and 17 years for disability-free life expectancy, even excluding the people with the highest and lowest 5% of incomes leaves gaps of 6 and 13 years respectively. Thus, the people in the middle of the social gradient have worse health

Fig. 2. Areas of action across the life course



Source: Fair society, healthy lives: strategic review of health inequalities in England post-2010 (9).

Fig. 3. Differences in life expectancy within a small area in London



than those at the top. Fig. 3 shows this gradient. Almost a year of life expectancy is lost for each stop on the London Underground Jubilee line moving east from Westminster.

Tackling inequalities in health is not a policy or programme aimed only at the most vulnerable people. It should aim at improving the health of a broad spectrum of the city population.

Fair society, healthy lives (9) suggests that: "To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage." They call this proportionate universalism. The programmes similar to the Sure Start programme in the United Kingdom conducted in several countries and cities to reach and support disadvantaged children through childcare and the education system exemplify this approach.

4.1.3 Assessing challenges and opportunities for decreasing the health gaps

One approach or programme will clearly not fit all situations. Different groups face different challenges and need differentiated approaches to meet them.

Complicating this situation further is the fact that the specific characteristics of the people facing high health risks may be more important in various situations or settings. For example, a recent study in India *(18)* indicated that sex is a more important factor than income in relation to initially receiving care but less important in relation to continuing care. In cities in the European Region, the needs and assets of local inhabitants living in poverty may differ from those of immigrants with low income, and within these groups, the needs and assets of men and women may also differ. Customized programmes may be difficult to provide, but it is important to assess how programmes and projects to tackle inequalities in health can be sufficiently flexible to take into account sex, age and the principle of proportionate universalism.

4.1.4 Interacting with social and professional groups

Broad participation in decision-making has long been a principle of the WHO Health for All policy and of the Healthy Cities movement. In tackling the social determinants of inequalities in health, however, the participation and involvement of local people needs to move to a higher dimension to make a difference.

Even when decisions are taken at the international or national level, how people living at a local level view, interpret or apply them can make a difference. For example, one of the principles of action of the Commission on Social Determinants of Health *(2)* is to tackle "the inequitable distribution of power, money and resources". The level of income can be strongly influenced by global trading conditions, and the minimum wage is usually set at the national level. However, in cities and villages throughout the European Region, some people are happy to pay less than the minimum wage to the migrant workers they employ. Only through broader and deeper participation can there be greater understanding and acceptance of the need to tackle the distribution of power, money and resources, the need for more equitable societies and perhaps a different pattern of development and greater respect for the resources consumed *(19)*.

Some cities have already attempted innovative means of broader participation. In Horsens, Denmark, for example *(20)*, "Citizens' groups, a citizens' council and forums have been established with the objective of improving cooperation and dialogue between the Municipality and its citizens. All conceivable methods of disseminating information are used, such as briefings and invitations to citizens via the local press, local television, the Internet, folders delivered to homes, telephone contact, study groups,

future-oriented workshops and the like." In Sandnes, a Children's City Council has been established to "encourage young people to increase their understanding for and participation in the Municipality's political activity and to give them the opportunity to manage their own interests in planning" *(21)*. In this case, children are involved, for example, in compiling information on how they use local space for walking or playing, and this information is incorporated in urban planning. At the other end of the age scale, cities such as Brighton and Hove have an elected Older People's Council, to ensure that older people are involved in decision-making, their needs are recognized and met and their contribution acknowledged and valued.

Those at the lower end of the socioeconomic gradient, or with specific health problems, are frequently labeled as "disadvantaged", "vulnerable" or "high risk" and are considered as being people to whom or for whom things must be done, rather than people with whom action can be taken. Work on asset-based community development indicates that social capital, reflected in people's skills, knowledge and networks, is a greatly underutilized resource *(22)*.

Social marketing skills can provide greater understanding of why people behave the way they do, what they value and aspire to and what motivates or demotivates their actions. By understanding, encouraging and releasing the energy, skills and desire for good health that people already have, even the people in the so-called vulnerable groups can become part of the solution, taking responsibility for and leading actions to tackle the social determinants of health.

Any city has its movers and shakers: its experts in both the professional and the practical sense. The right person in the right place at the right time can make a difference *(23)*. Both the public and private sectors must be fully involved. Nongovernmental organizations frequently include top experts among their ranks and, de facto, individuals who are committed to a particular cause.

The mental health of the city population can be one of its greatest assets. A mentally and physically healthy local population is also in the interests of private enterprise both as a local source of labour and as pool of potential customers. The recent increased interest in socially responsible enterprises *(24)* might offer a window of opportunity for getting inequality in health higher on the agenda of local private enterprises.

4.2 Place

Cities are affected by policies decided at international and national levels over which they frequently have little control. Nevertheless, in certain cases, these policies can be used to good advantage as levers for local policies. Some countries have made innovative efforts to develop national policies for tackling the social determinants of inequalities in health *(25)*, and the evaluation of Phase IV of the WHO European Healthy Cities Network clearly indicated that the existence of a national policy facilitated similar action at the local level *(26)*. Some of the most effective interventions appear to be those carried out simultaneously at different levels. Achieving such alignment creates synergy and facilitates impact.

Cities need to clearly define how they can shape the determinants of health, developing healthy places designed to promote physical and mental well-being, social cohesion and protection of the natural environment, called for by the report of the Commission on Social Determinants of Health *(2)*.

The guidelines for healthy urban planning *(27)* developed through the WHO European Healthy Cities Network suggested that planning for healthy urban places should promote the following:

- healthy exercise;
- social cohesion;
- quality housing;
- access to employment opportunities;
- access to social and market facilities;
- local low-impact food production and distribution;

- community and road safety;
- equity and the reduction of poverty;
- good air quality and protection from excessive noise;
- good water and sanitation quality;
- conservation and decontamination of land; and
- climate stability.

Many of these objectives could also affect inequality in health, especially if they focus on disadvantaged areas or are directed to pay specific attention to the needs of various population groups along the social gradient.

Making a difference requires a new awareness of local space. City development and the provision of services are frequently funded from different sources. These may not always be adequately coordinated. A recent report from HM Treasury in the United Kingdom *(28)* for example, describes attempts in several pilot areas to map public services, how they are funded and what real estate they own, and through customer journey mapping to view services through the eyes of customers, showing how individuals interact with services and how this could be improved.

The results of this total-place effort indicate a certain amount of waste and duplication and opportunities to make savings through joint working and therefore to release funding for other uses. It also indicates how a more joined-up approach to asset management across places both in the maintenance and use of existing property and in relation to new capital investment can potentially increase efficiency and improve outcomes.

Multiple use of sites, even specialized buildings such as schools, can both reduce expenses and help cut across cultural barriers between sectors. Reaching out to vulnerable groups through local sites they already use, such as shopping centres, can also be effective. For example, in Milan there has been an attempt to bring psychological support nearer to the citizens since 2009 by offering free consultations at 23 pharmacies.

Sometimes changes in the way people use space can be as simple as encouraging a more egalitarian educational or discussion process by changing the seating in classrooms or meeting rooms from rows facing the front to a circle. Similar changes can be effected by the design of public buildings, recreational and green spaces to encourage physical exercise and social interaction. Place and space can strongly affect mental well-being *(29)*.

4.3 Process

Put very simply, the governance of the city is the process by which decisions are made and are implemented or not implemented. It includes all the processes through which public and private institutions, formal and informal interest groups and individuals identify priorities and resolve conflicting interests.

All cities have structures and processes for policy-making and planning, for carrying out their various remits and legal responsibilities and for managing change. The effectiveness of these structures and processes needs to be examined, especially in developing action across sectors, which is still one of the main obstacles to tackling the social determinants of health.

New purpose-specific processes and structures for tackling the social determinants of health may have to be established. However, existing processes and structures for raising awareness, building evidence, formulating policy, implementing, evaluating, regulating, funding and coordinating activities can also be adapted. Some years ago, the City of Milan *(30)*, supported by the local university, reviewed "projects and initiatives planned or already started up in Milan that combine physical, social and environmental aspects". This led to the creation of an atlas of such projects, an assessment of intersectoral collaboration and the development of pilot projects to try to deal with some of the problems of intersectoral working.

Linking to successful structures and processes in other sectors could ensure that reducing the health

What structures and processes for working across sectors are already in operation in your city?

Are they effective in encouraging joint planning, joint funding or at least mutual exchange of information and experience?

Could they be adapted to tackle the social determinants of health?

Should new processes or structures be set up, and how can these be given high visibility and support?

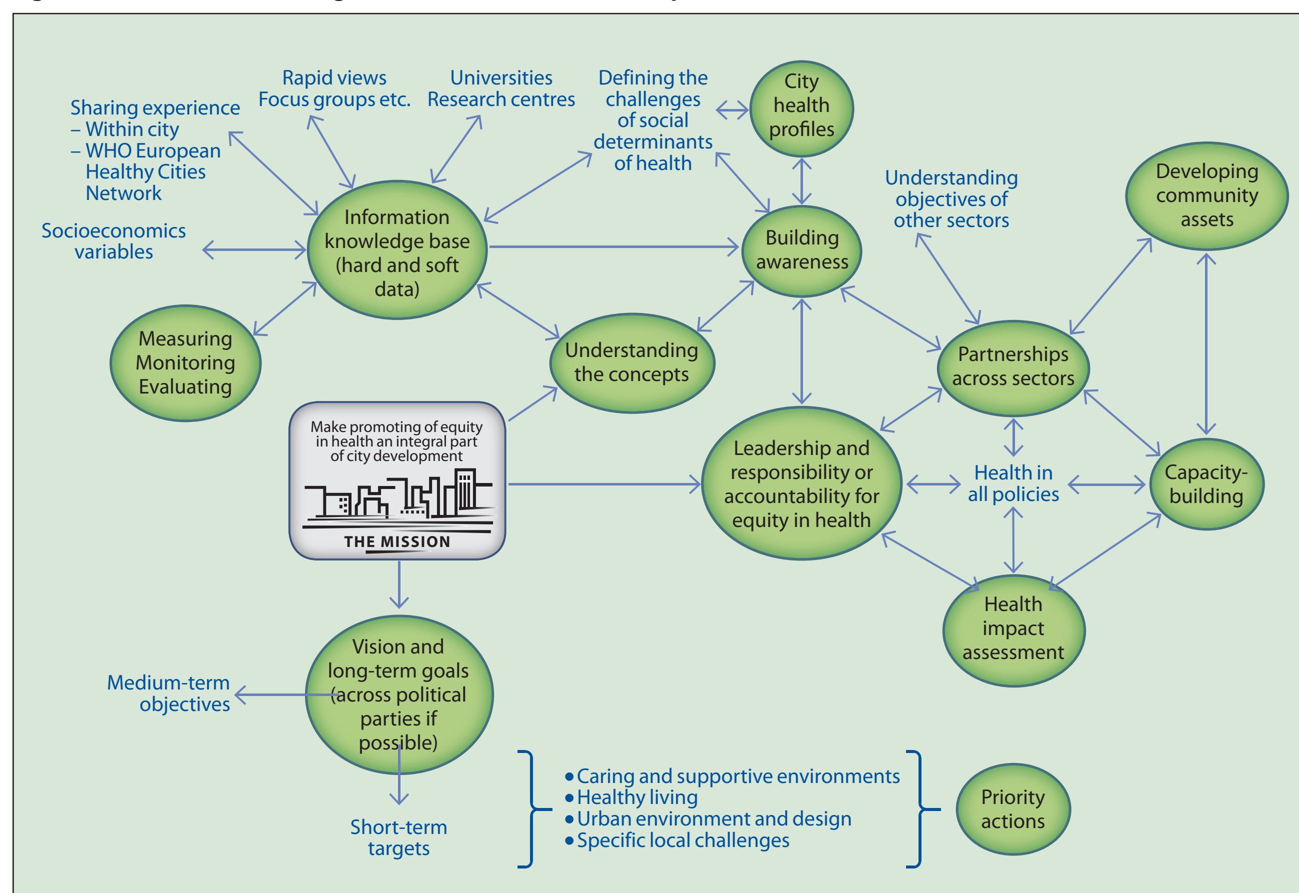
gaps becomes a constant whole-of-local-government goal. For example, although considerable attempts have been made in Ireland at the national level to establish intersectoral structures for implementing health policy, these have had limited success. Consequently, in 2007 "it was decided to latch on to an existing, successfully operating mechanism for intersectoral action, that is, the cabinet subcommittee dealing with social inclusion, operating and chaired by the office of the Prime Minister" *(31)*.

5. Critically examining processes and structures to tackle the social determinants of health

Starting from the mission, Fig. 4 shows graphically the critical factors – indicated by the green circles – with which cities must be concerned if they are to successfully tackle the social determinants of inequalities in health. The main links between these factors and the ultimate aim of making equity in health an integral part of city development are indicated by means of a simple mind map.

The factors critical to success in tackling the social determinants of health were selected based on the evaluations of Phases III and IV of the WHO European Healthy Cities Network; the report of the Commission on Social Determinants of Health *(2)*; a broad range of relevant documents from countries and cities across the European Region; and discussions held during the Annual Business and Technical Conference of

Fig. 4. Critical factors in tackling the social determinants of inequalities in health



the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in June 2010 in Sandnes, Norway.

A mind map was chosen to show graphically the main action points in the green circles, the multiple links between critical factors and certain options and prerequisites, such as the need to understand the objectives of other sectors to develop partnerships with them.

Given the very differing situations in cities in the WHO European Healthy Cities Network, the mind map is intended to indicate both the complexity of the process but also the flexibility with which cities can choose the critical point of entry relevant to their stage of development in tackling inequalities in health.

5.1 Understanding the concepts

The cities in the WHO European Healthy Cities Network are fortunate that, by joining Phase V, the top political level in the city (the mayor and the city council) has already formally committed to tackle the social determinants of health and reduce the health gaps.

However, support from the highest level is essential but not sufficient. Understanding and support must disseminate throughout the entire city management process and in the population at large. It must also be sustainable beyond the term of office of the current local council. Level one of the ladder of progress outlined above is not a once-and-for-all step. Once briefed on tackling the social determinants of health, politicians and decision-makers may change their role, especially following elections, so that healthy city coordinators are constantly briefing the newcomers. The public needs to be continually reminded of the issues and of the channels through which they can voice their opinions.

Do you have an easily accessible definition or explanation of the concept of equity in health?

Regularly compiled data should reflect sex, age and socioeconomic variables such as income, education and occupation.

The knowledge needed to shift to an asset-based approach should be compiled and analysed.

5.1.1 What does equity in health mean?

The report of the Commission on Social Determinants of Health *(2)* defined health inequities as systematic differences in health considered to be avoidable by reasonable action and therefore unfair, in accordance with the WHO definition *(32)* of health inequities as "avoidable inequalities in health between groups of people within countries and between countries". Various actors in this field prefer to use health inequality (and inequalities) and others health inequity (and inequities) to refer to these avoidable differences in health. These actors mostly agree on using the word equity as the positive term (health equity, equity in health) and not equality.

Considerable efforts have been made in the WHO European Region to broaden understanding of the policy implications of tackling health inequalities. In the early 1990s, discussion publications *(33–35)* clarified what is meant by health equity, how inequalities might be measured and what policies and strategies would be most likely to reduce the gaps. Intended for a non-technical audience, these publications have been translated into more than 20 languages.

Are these publications available in your language, or is similar national material available?

Differences or variation in health can be measured from standard health statistics, but not all differences are inequitable. As Margaret Whitehead *(33)* states, "The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and

avoidable but, in addition, are also considered unfair and unjust."

She defines seven broad categories of variation in health:

1. natural, biological variation;
2. health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes;
3. the transient health advantage of one group over another when that group is first to adopt a types of health-promoting behaviour (as long as other groups have the means to catch up fairly soon);
4. health-damaging behaviour in which the degree of choice of lifestyles is severely restricted;
5. exposure to unhealthy and stressful living and working conditions;
6. inadequate access to essential health and other public services; and
7. natural selection or health-related social mobility, involving the tendency for sick people to move down the social scale.

The consensus view suggests that health differences determined by the first three categories would not normally be classified as inequalities in health. Many people would consider those arising from categories 4–6 to be avoidable and the resulting health differences to be unjust. In the seventh category, involving the tendency for sick people to become poor, the original ill health in question may have been unavoidable, but the low income of sick people seems both preventable and unjust.

Human beings vary in health, as they do in every other attribute. Some of the differences in health between men and women are biological variation. For example, ill health due to sex-specific problems such as cervical and ovarian cancer and the higher incidence of osteoporosis among older women compared with older men are attributed to biological differences rather than to unjust social or environmental influences. However, biology cannot account for much of the differences between groups in society, including that between men and women.

The crucial test of whether health differences are considered unfair depends largely on whether people chose the situation that caused the ill health or whether it was mainly out of their direct control *(36)*. For example, through lack of resources, poorer social groups may have little choice but to live in unsafe and overcrowded housing, to take dangerous and dirty work or to experience frequent bouts of unemployment. The sense of injustice is heightened in such cases, as problems tend to cluster together and reinforce each other, making some people very vulnerable to ill health.

Whitehead *(33)* therefore suggests that:

> Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided.

Equity is therefore concerned with creating equal opportunities for health and with minimizing health differences that are avoidable and unfair.

Equity in health care is defined as:

- equal access to available care for equal need;
- equal utilization for equal need; and
- equal quality of care for all.

The European Region has experienced vast changes since these were published in the early 1990s. There is increasing evidence on the social determinants of health and more sensitive and reliable measures for assessing inequalities in health. In 1997, the WHO European Healthy Cities Network commissioned *Social determinants of health: the solid facts (37)*, designed to explain to policy-makers "the role that public policy can play in shaping the social environment in ways conducive to better health". In presenting their evidence, contributing experts emphasized the need for a more just and caring society.

Is *Social determinants of health: the solid facts* available in your language?

In 2007, the WHO Regional Office for Europe invited the authors of the first discussion papers to reconsider the concepts and principles, and possible strategies for tackling social inequalities in health, taking into account recent research. Their findings are presented in two publications available in English and in Russian *(38,39)*.

At the global level, the WHO Commission on Macroeconomics and Health put the economic argument more firmly on the agenda, showing "how disease is a drain on societies, and how investments in health can be a concrete input to economic development" *(40)*. The Commission focused largely on low-income countries, but later reports indicate that better health could contribute substantially to economic growth in countries in the European Region *(41)*.

In 2005, WHO established a Commission on Social Determinants of Health. Nine knowledge networks collected and synthesized evidence on (1) plausible causal relations; (2) key areas in which action should take place; and (3) effective practices and interventions for addressing socially determined inequalities in health globally *(42)*. The Commission published a report in 2008 *(2)* calling for closing the health gap in a generation. Following the huge body of evidence gathered by research groups across the globe and made easily accessible on the web, the Commission hopes for a global movement perceiving equity in health as a societal good and offers examples of what works *(2)*. A large group of experts, again under the leadership of Michael Marmot, is carrying out a similar review for the European Region. A consultation report will be available by September 2011, and the final report is expected in 2012 *(43)*.

The principle of equity in health has gained acceptance in the work of the wider United Nations System, especially by recognizing poverty as a major cause of ill health and mortality *(44)*. The United Nations Development Programme *(45)* and World Bank *(46)*, for example, have presented ambitious policies to reduce poverty and provide guidelines for poverty impact assessment. The EU has strongly focused on reducing poverty and social exclusion, with countries called upon to formulate national plans for reducing them *(47)*. The EU strategy for public health for 2008–2013 *(3)* gives prominence to reducing inequalities in health.

Although the terms poverty and inequality are often used interchangeably, poverty refers to the most disadvantaged people, whereas inequality reflects the full social gradient. The report of the Commission on Social Determinants of Health *(2)* stresses that not only the needs of the most vulnerable people should be tackled but also the social gradient in health that runs from the top to the bottom of the socioeconomic spectrum. The report provides clear evidence that not only the people with the lowest incomes live shorter lives and have longer periods of ill health than people with the highest incomes. At each step along the gradient, the people on a lower step have worse health than those on the steps above them.

Although the literature does not agree on how socioeconomic inequality in health should be conceptualized *(48)*, it is usually characterized in terms of income, education, occupation and to some extent, income-related indicators such as home or car ownership. It is frequently analysed by sex, age and area-based measures, for which some countries have developed complex indicators of deprivation. The European Health for All policy adopted in 1999, Health21 *(49)*, included vulnerable groups such as women, people with physical or mental disabilities, older people, immigrants and refugees under the equity in health label, as do many cities.

Both the reports of the Commission on Social Determinants of Health *(2)* and those of other research-

ers *(50)* emphasize that tackling the determinants of health does not automatically tackle inequalities in health.

Both the evaluation of Phase IV of the WHO European Healthy Cities Network *(51)* and its most recent annual reports indicate that decision-makers do not find the concept easy to understand, even in cities where equity in health has nominally been on the agenda for some time. As a report presented at the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in June 2010 stated, it is "difficult to fathom whether they really understood the concept and the implications of health and health equity embedded in all local policies" *(52)*.

Most European languages do not distinguish between equity and equality as English does. Particularly in some cities in eastern Europe, for example, the word "justice" implies tackling inequality. What is important is understanding the concept; cities can then find the most appropriate word in their language to describe that concept.

5.2 Building awareness

Once cities have clarified the concepts and principles of equity in health and agreed on an appropriate definition in the local language, cities must build up awareness of the need to act, not only in the health sector but across all sectors.

How would you assess recognition of the social determinants of equity in health throughout the city administration, in the mass media and on the street?

What efforts have been made to ensure that the complex issue of equity in health and its policy implications are widely understood (face-to-face meetings, workshops, the mass media etc.)?

The report of the Commission on Social Determinants of Health and similar national reports make the case for tackling the social determinants of inequality in health. In England, for example, *Fair society, healthy lives (9)*, while stressing that reducing health inequalities are a matter of fairness and justice, also shows that such action will benefit society in many other ways. For example, economic benefits would include reducing some of the losses associated with inequalities in health, such as productivity loses, reduced tax revenue, higher welfare payments and increased treatment costs.

Fortunately, given the work already carried out in the WHO European Healthy Cities Network, cities have a wide range of possible options for building awareness, including the following.

- Present the results of the report of the WHO Commission on Social Determinants of Health report to a wide range of stakeholders, including the mass media.
- Distribute and discuss *Social determinants of health: the solid facts (37)*, available in more than 20 languages.
- Distribute parts of *Social determinants of health: the solid facts* relevant to specific sectors as a handout when approaching these sectors.
- Run awareness-raising workshops, such as one held in New Zealand *(53)*.
- In the Bro Taf area in Wales, for example, the health authority issued a Declaration on Health Inequalities pledging to reduce inequalities in health in partnerships with others and gave a copy of this Declaration to every staff member *(54)*.
- Peer visits: invite people from more experienced healthy cities to share their experiences.
- Offer short training courses on health impact assessment, which is directly related to raising awareness of the social determinants of health. Both the WHO European Healthy Cities Network and specific cities have ready-made packages that could

be used as part of an awareness-building process. Outside Europe, Ontario organized a conference on equity-focused health impact assessment in October 2010, and Australia has developed a framework for equity-focused health impact assessment.

- Local universities and research centres could be encouraged to carry out research into topical issues such as the possible health effects of the present economic crisis.
- Discussions with local interest or focus groups can be initiated, implementing the asset-based techniques referred to below.

Reports from the evaluation of the WHO European Healthy Cities Network indicate that clearly defining the equity principle in a broad section of local policy documents, and not only in health documents, helps raise awareness and promote action.

Do all relevant city policy documents clearly define the principle of equity in health and not only those related directly to the health sector?

In 1986, a WHO publication *(55)* stated that one of the indicators of yearly progress in countries should be the change in inequalities in health. Many cities, and all national governments, report regularly on the level of their public debt and their inflation and unemployment rates, for example. Regularly reporting changes in the social determinants of health and in the health of the most vulnerable people as an indicator of a city's overall progress towards a fairer and more sustainable society could focus the attention of policy-makers and the public on this issue.

Do you report regularly to the city council on trends in inequalities in health: for example, in regular annual reports and in background documents to the annual budget?

5.3 Strengthening and sharing the information and knowledge base

The vital importance of strengthening the information and knowledge base cannot be stressed strongly enough, and this is vital at whatever level on the ladder of progress a city is currently. Reliable information is required to attempt the complex process of tackling the social determinants of inequalities in health and of monitoring and evaluating progress.

This does not solely mean compiling and analysing sophisticated epidemiological data, although this should be aimed for in the longer term, but using all kinds and sources of reliable data available in the city to achieve four main aims:

- defining and measuring inequalities and their causes;
- monitoring changes on a regular basis;
- evaluating progress and the success or lack thereof in implementing policies and interventions; and
- assessing the effectiveness of actions to promote equity in health.

5.3.1 How can cities improve their information base?

Cities in countries with a long tradition of monitoring socioeconomic inequalities in health are fortunate in having access to a wide range of relevant data at the small-area level. One participant at the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in June 2010 even described this as being overwhelming: "a sea of data". Other cities have little information below the city level and even less information linked to socioeconomic variables. Cities could take several steps to improve the database in a reasonably short time.

For example, are data compiled at the national level made available for use at the local level? If not, cities need to lobby for this important tool.

Relevant data may be regularly collected in the health sector and other sectors but without reference to variables such as income, occupation and education. Socioeconomic variables may be able to be linked to such data without considerable increase in cost.

Information collected by research centres and universities frequently remains in the hands of the researchers, to be published in journals read by a very narrow readership.

Local universities should be a valuable resource for research and policy analysis. As the Mayor of London stated recently, although London is home to internationally recognized universities and research institutes, there is "little dialogue between policy-makers, researchers, practitioners in health and social care and community groups working with local people". Whereas, as the Mayor proposes, with their resident expertise, local universities have the potential to become world leaders in creating knowledge for tackling the social determinants of health *(55)* – as do many other cities in the WHO European Healthy Cities Network.

Nongovernmental organizations and private enterprises are also valuable potential sources of information. Many nongovernmental organizations frequently survey the population group or the health issue for which they advocate. Some private enterprises are interested in local market surveys and might be encouraged to partly fund local profiles.

Have the reliable data sources in the city, within and outside the health sector, been assessed, and have ways been considered to fill possible gaps?

Could socioeconomic variables be linked to regularly collected data?

Departments outside the health sector may also be collecting relevant data that the city health department is not yet using for health policy purposes. Some years ago in Lithuania, for example, an attempt was made to assess all sources of relevant data for their regularity and reliability, and based on these data, without compiling new data, a report on equity in health was presented to the parliament *(57)*.

Involvement in international projects has been shown to be an effective way both of improving the quality of local data and ensuring that they are internationally comparable. For cities in EU countries, work carried out under the poverty or social cohesion label might provide a useful source.

If regularly collected data do not reflect potential socioeconomic inequalities, the results of simply walking or driving through disadvantaged areas can be recorded in what has been called a walk or windowscreen audit. Göteborg, Sweden, for example, has prepared a manual to involve local people in assessing whether neighbourhoods are safe *(58)*.

Reaching out to people in local jobs, which differ in educational requirements, and for which the approximate pay is known, could also offer a preliminary picture of the needs of people situated on different parts of the social gradient.

Where local information is very underdeveloped, much more could be done in sharing information between cities with similar characteristics, as a temporary measure. For cities in EU countries in relation to the poverty and social exclusion programme, the EU can draw on an EU programme (PROGRESS employment and social solidarity programme) to support mutual learning through a variety of instruments, such as the financing of stakeholders networks, peer reviews or meetings with people experiencing poverty *(47)*.

5.3.2 Analysing and presenting the data

Analysing and presenting the data is particularly important to convince decision-makers that they need to act. The results should be available in a popular form on the city web site or as a regularly published document.

Several cities could reach this milestone within Phase V by preparing or updating city health profiles. However, the annual reports from cities for 2009 indicated that 22% of the cities in the WHO European Healthy Cities Network had not updated their city health profile for more than five years. Others have consistently used this tool as an effective means of presenting the challenges. Belfast, for example, has been able to make ten-year comparisons showing that, although overall health has improved, many of the health gaps have widened and "tackling disadvantage and its root causes across sectors must be a priority for political decision-makers and policy-makers" *(59)*.

What also needs to be checked is whether the city health profile covers a sufficiently wide range of the social determinants of health, whether the city health profile analyses how these determinants influence health outcomes and whether it highlights specific local issues especially relevant for equity in health. Including as wide a range of stakeholders as possible in the process of developing the city health profile constitutes the first step in creating partnerships to tackle the social determinants of health.

The WHO European Healthy Cities Network has guidelines on developing city health profiles *(60)*. Several good examples of city health profiles could serve as a model for cities just starting out.

When was your city health profile last revised? Can it be considered reasonably up to date?

Does the city health profile or a similar report cover the main social determinants of inequality in health?

Does the process of formulating this report include as wide a range of stakeholders as possible?

The city health profile or other informational material will only have influence when shared and widely discussed. In addition to discussion by the city council, such documents should be publicized through the mass media, made available on the web and discussed by a wide range of stakeholders. Feedback from such discussion could indicate possible solutions.

5.3.3 *Using other available tools and expertise*

Social marketing expertise in segmenting population groups and attempting to understand the situation from their viewpoint can be of value *(61)*.

Several cities prepare profiles for special groups such as the healthy ageing profiles for which the WHO European Healthy Cities Network has guidelines *(62)*.

Presenting information on maps showing local inequalities in health has been found to be a valuable tool in attracting the attention of local politicians. Examples include the Turku health profile or the web site of the Association of Public Health Observatories in the United Kingdom, through which interactive maps can be created for 32 of the health profile indicators and local authority areas *(63)*.

Combining the "hard" epidemiological data with "softer" information is vital. The latter should also include the experience and considered opinion of those working in the field.

Have the data in your city been reviewed to assess their adequacy for monitoring and evaluating changes in the social determinants of health? Have ways of filling possible gaps in information been defined?

5.3.4 *Asset-based community development*

The method of asset-based community development brings understanding not only of how those living with a particular problem experience this, including the strengths they build on to cope, but also how they believe they could begin to deal with it themselves, given a little support.

Discussion at the Annual Business and Technical

Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in 2010 indicated that the time has come, especially during the present economic recession, to focus less on the problems and more on the strengths and assets available in the community to tackle the challenges. Tools are available for assessing social capital, the skills and knowledge of local people and the physical and technical assets of local associations and institutions *(64)*. In the United Kingdom, for example, Local Government Improvement and Development has developed a set of guidelines to enable local authorities to use an asset-based approach *(65)*.

Investigate the development of asset-based methods within the specific culture of your city.

Two related issues also need to be considered here – putting the social determinants of health in context and taking a forward-looking stance. The social determinants of health cannot be seen in a vacuum. They are part and parcel of overall city development and of growth and development at the national and international levels. The social determinants of health must be viewed within this overall political and economic context and in relation to possible future challenges and opportunities, such as future demographic trends, the ageing of the population, migration in and out of the city, changes in the economic climate of the city, environmental change and international trade agreements.

Discussion with all types of community groups, associations, nongovernmental organizations and public and private enterprises in the health promotion field could enhance the knowledge base, identify stakeholders beyond those usually invited for collaboration and uncover potential leaders and champions for the social determinants of health.

5.3.5 Monitoring and evaluating progress

In recent years there has been a huge increase in the research on measuring inequalities and their causes. However, the relevant literature appears to show that more effort is frequently put into writing policies than into monitoring and evaluating their implementation. Even less effort is made to evaluate the effectiveness of actions intended to affect the social determinants of health. This area is woefully neglected or less than appropriate methods of research have been used.

Such evaluations would have more political impact if, in addition to their success in closing the gaps, there was also some indication of their economic impact. For example, a recent attempt to improve the health of postal workers (a group probably in the lower half of the social gradient) employed by Royal Mail *(66)* in the United Kingdom indicated not only an improvement in their health but also in the cost and quality of postal services provided.

5.3.6 Experience and expertise

Finally, information is not only about statistics or even subjective opinions but also about experience and expertise. The EU has established a European Health Inequalities Portal *(67)* that provides information on what can and is being done to reduce inequalities in health, makes links to important resources, documents and organizations and provides the contact details for professionals working in the field.

The WHO European Healthy Cities Network is a rich source of expertise, and more could be done to share this expertise. Participants at the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in 2010 suggested peer reviews and buddy systems. The results of peer reviews can be extremely valuable both for the reviewers and those being reviewed *(68)* and for the WHO European Healthy Cities Network as a whole.

5.4 Maintaining political commitment for tackling the social determinants of health

As seen above, participation in the WHO European Healthy Cities Network requires the commitment of a city's mayor and city councillors. Tackling the social determinants of inequalities in health, however, transcends the electoral term of a city council, and longer-term political commitment is essential.

Involving all political parties in the social determinants of health process can be sensitive, however, as participants clearly stated at the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in 2010, when they were asked this question in the working groups organized to discuss the first draft of this framework. Defining the situation is perhaps less politically sensitive than the process of formulating policies and strategies. It is therefore possible that, if all parties in the city council were more closely involved in assessing the situation regarding inequalities in health, a certain level of collaboration across political parties at this initial stage might help to maintain sustainability over the longer term.

There are examples of such cross-party collaboration at the national level. Some years ago, for example, when the Netherlands launched two five-year research programmes on equity in health *(69)*, care was taken to invite a member of the right-wing party to chair the parliamentary supervisory committee. In Lithuania, by closely involving the parliamentary health committee and parliament itself in developing and presenting a report on equity in health, all political parties supported the need for a policy to reduce the gaps *(70)*. When Sweden developed its ground-breaking policy tackling the determinants of health, all the main political parties were represented on the parliamentary commission overseeing the process *(25)*.

Despite the valid concerns expressed regarding the sensitivity of trying to involve all political parties, particularly for some cities, it is difficult to imagine that any political party would openly oppose the principle of equity in health, and health could possibly become a unifying issue.

Have you investigated ways of involving all political parties in the city council in gaining commitment for tackling inequalities in health?

5.5 Creating and maintaining partnerships across sectors

Evaluations of attempts over the past 30 years to implement the Health for All policy invariably state that one of the main obstacles has been the difficulty in creating partnerships across sectors. Some of the obstacles to building commitment and sustaining partnerships for the social determinants of health have been defined as:

- the static and inward-looking culture of statutory sector organizations;
- the dominance of professional cultures and ideologies in imposing their own solutions on communities;
- competing and conflicting priorities;
- the skills and competencies of staff in public services; and
- the capacity or willingness of community members to get involved.

These are very real issues, and even in cities that have been trying for years to close the gaps, other sectors are simply not convinced that they might have anything to do with health. For example, one participant at the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in 2010 said that when an e-mail was sent out inviting colleagues in other sectors to join a discussion on the social determinants of health, a re-

ply was received saying "I think you sent this invitation to the wrong person."

This issue is closely linked to that of building awareness discussed above, but it goes further and is the backbone of reaching levels four and five on the ladder of progress. The aim is to motivate or trigger action. Achieving this requires following two basic principles:

- being well prepared to explain what needs to be done to the outside world, the aims and objectives and the reasoning behind these and the assets that can be brought into a potential partnership, including knowledge, skills and commitment; and
- being prepared to understand optimally the aims and objectives of prospective partners.

In Milan, Italy, for example, when intersectoral pilot projects were to be initiated, considerable care was given to organizing round-table discussions to which each prospective partner would bring its sector's position, vision of the issues and knowledge of the neighbourhood. This process was strengthened by individual meetings to discuss certain issues in further depth and to continually broaden the network of those involved *(30)*.

The health sector can adapt tools developed for awareness-building to be prepared for collaboration across sectors. For example:

Develop a short handout to explain why inequalities in health should be tackled.

Develop a simple slide presentation with notes.

Equally importantly, it cannot continue to be assumed as in the past that other sectors want to join the health sector in achieving its priorities. Better tools are needed to show that closing the health gaps not only meets the aims of the health sector but can also benefit other sectors. This cannot be a one-way street in which other departments are simply "informed" about inequalities in health and the main determinants, which may fall in their area of responsibility. Involving other departments in the initial stages of assessing the situation could help to gain their commitment.

The health sector needs to reach out to enquire about the objectives of other sectors, discussing at an early stage possible converging or conflicting interests. Only then can possible solutions be found when there appear to be conflicting objectives. No wheels need to be reinvented; many good business management books offer lessons on how to understand prospective partners.

Carry out stakeholder analysis in areas of challenges for equity in health or proposed strategic policy intervention, to look for possible allies and potentially conflicting interests.

An attempt to understand better the objectives of other sectors could uncover further common or converging objectives, thereby indicating possible "easy" partners. In all cities in the WHO European Healthy Cities Network, the health sector has collaborated to some extent with other sectors. Certain sectors already have an interest in health, if not in inequalities in health as such.

Reducing road crashes, accidents at work and air pollution are among the most common examples, as are links to the social welfare sector. These sectors might therefore be natural allies and could perhaps be brought on board more easily for quick wins. For cities just starting on the social determinants of health process, starting with one of these traditional or easy partners might be helpful.

Sometimes the question is how to package messages when approaching new partners. For example, when Ireland wanted to prohibit smoking in pubs, the trade unions covering people who work in pubs were brought on board first, and the issue was presented

very much as one of protecting the health and rights of pub workers *(31)*.

If partnerships for equity in health are to be successful, cities need to secure understanding with potential partners *(71)*, ensuring:

- a shared vision and agenda;
- agreed aims and objectives;
- agreed roles and policy instruments;
- openness about self-interest and possibly conflicting objectives;
- mutual respect, trust and ability for mutual learning; and
- an agreed method of dealing with disagreements *(72)*.

5.6 Health impact assessment – one type of intersectoral work

Health impact assessment is already being developed across the European Region as an essential and potentially powerful tool for tackling the social determinants of health and was one of the core themes for Phase IV of the WHO European Healthy Cities Network. Fifteen cities joined a subnetwork to develop the health impact assessment methods. Nearly 40% offered training in health impact assessment, and 30% actually carried out one or more health impact assessments. The subnetwork for health impact assessment of the WHO European Healthy Cities Network has developed several guidelines *(73)* and training packages. Indeed, several cities in the WHO European Healthy Cities Network are recognized pioneers in health impact assessment.

The WHO Gothenburg consensus paper on health impact assessment *(74)* defines health impact assessment as "a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population". As the 10th International Health Impact Assessment Conference in 2009 indicated, health impact assessment is being rapidly developed across Europe and is already a statutory requirement in some places. There are, however, few examples in which the distribution of effects within the population is actually examined.

Healthy cities are in a unique position at the local level to take this process further and assess how policies affect population groups. This should not become too heavy or burdensome. Some years ago in Edinburgh, for example, an attempt was made, using a simple matrix, to assess the potential effects of a proposed urban transport strategy *(75)* for affluent people and deprived people: young families, adolescents, older people, working people and unemployed people. Sweden's local authorities have also developed a matrix, and using this enables them *(76)* "to shed overall light on the consequences a policy proposal might have with regard to some of the key determinants of health. It is also possible to illuminate health impacts on groups with a less favourable health trend, on that part of the population that can be affected directly, and also on the entire perspective."

In Finland, an attempt is made to combine health impact assessment with social impact assessment in a process known as human impact assessment. A special project was developed to encourage municipalities to develop and execute human impact assessment so that this is integrated in their decision-making process.

Political support, improved data and training and access to the necessary expertise are essential for health impact assessment. Since some cities now have considerable expertise in health impact assessment, sharing this expertise and experience is one of the areas where the WHO European Healthy Cities Network can play a dynamic role. The health impact assessment subnetwork made proposals for carrying out peer review through the WHO European Healthy Cities Network.

The international literature indicates that what actually happens as a result of health impact assess-

ment is rarely followed up. Unless the methods can be demonstrated to be effective or ineffective in inducing change in policies assessed so that potentially negative effects on health and inequalities in health are reduced and potentially positive effects are enhanced, political support for this tool may wane.

Another area in which more work needs to be done is including economic assessment in health impact assessment, including estimating the costs of implementing the various recommendations *(77)*. Norway has paid considerable attention to such issues. For example, *Prescriptions for a healthier Norway (78)* identified the use of economic assessment as part of impact assessment and this was further described, supporting the development of guidelines for economic assessment in of health in both the health and non-health sectors. Norway also acknowledges distributional effects and recommends that they be explicitly included in economic analysis; socioeconomic groups are considered a natural unit for this *(79)*.

Health impact assessment is directly related to tackling the social determinants of health. Training courses in health impact assessment for decision-makers at all levels can therefore be an excellent introduction to tackling the social determinants of health. For example, the short courses on health impact assessment run by the Institute of Public Health in Ireland have been regularly overbooked, with high-level decision makers from many sectors requesting to take part. Two- and three-day courses are available in many cities for those looking for training to actually carry out simple health impact assessment.

Not all policies and programmes can be assessed for their possible effects on inequalities in health. One of the most crucial needs therefore is a screening tool to select the policies or programmes that might significantly affect inequalities in health. Simple screening tools have been developed in several cities. The Swedish Federation of County Councils, for example, has developed a health impact assessment tool, and the first question is "How is the health of different groups affected by the proposed policy decisions?" *(80)*. In the Bro Taf region in Wales, a policy audit checklist has been developed *(54)*. These and similar tools could be used to screen policies, especially in sectors that have been defined as being important for equity in health.

Have brief capacity-building health impact assessment courses been established for politicians and decision-makers in your city?

Are training courses in place for the people who will actually carry out health impact assessment?

Is a system in place for screening policies in key sectors, with emphasis on their potential effects on vulnerable groups?

5.7 Capacity-building

5.7.1 The healthy city team

Capacity-building within a city's healthy city team is essential. Evaluation of previous phases of the WHO European Healthy Cities Network indicate, not surprisingly, that the strategic location of the healthy city office and the management and communication skills of its staff are critical to success. Obstacles to success are reported as being continual organizational or personnel changes in city management and the lack of secure funding.

5.7.2 Shifting to an asset-based approach

This is a relatively new way of working, which to some extent requires that professionals reconsider where power and leadership lies in the community. As seen above, there are examples of guidelines in adopting this approach.

5.7.3 Effective intersectoral partnerships

Establishing effective intersectoral partnerships, which are essential to tackling the social determinants

of health, require capacity-building both within the health sectors and for prospective partners. In Greenwich, for example, a course for staff, Health: Everyone's Business, is "deliberately targeted at officers from all departments within the council rather than only those working in obviously health or social care areas" *(81)*. This is closely linked to the issue of awareness-building and to levels three, four and five of the ladder of progress.

To achieve levels four and five, health impact assessment or at least a culture of health impact assessment must be in place. That is, even when health impact is not formally assessed, decision-makers must be aware that their decisions could affect inequalities in health. Some cities are fortunate in having national advisers or guidelines readily available. Although local situations differ and the transfer of experience from other cities may not always be appropriate, the sharing of available guidelines, tools and training packages could save time, stimulate thinking and jump-start local efforts.

5.7.4 Providing information, technical and other support

Capacity-building involves more than training and guidelines. The health sector must be able to provide easily accessible information and technical support to prospective partners, both professional and lay partners. As the asset-based approach expands, this will also include very practical issues such as providing meeting spaces and access to the Internet.

Is a system in place to support potential partners in terms of accessible information, expert advice, guidelines and examples of good practice, meeting spaces, technological support, access to the media, etc.?

5.8 Developing a clear map of the way forward – vision, objectives and targets

5.8.1 Health planning experience in the WHO European Healthy Cities Network

City health development planning was the main focus of Phase III of the WHO European Healthy Cities Network (1998–2002). At the annual meeting of the WHO European Healthy Cities Network in 2000 in Horsens, the city mayors and political leaders signed the Horsens Declaration on Action for Equity in Europe *(82)*. They spelled out the need for:

- operationally defining equity in health;
- measuring and monitoring inequalities in health;
- auditing policies to contribute towards the goal;
- a vision and strategy clearly defining equity as the core value of a city health development plan and the targets to achieve it; and
- the necessary policies and programmes.

More than a decade later, although there have been excellent examples across the European Region of cities reconsidering how they plan for health and therefore the place of health on the political agenda, there is still some way to go in tackling the social determinants of inequalities in health. Cities have taken various paths, all of which are valid. These include what might be called classic Health for All–type plans, health interventions in selected sectoral plans through bilateral agreements or integrating health objectives in overall city development plans. An evaluation *(83)* of the evolution and process of city health planning in the WHO European Healthy Cities Network calls these planning types I, II and III.

In Phase IV of the WHO European Healthy Cities Network, 17 cities developed comprehensive type I city health development plans, outlining their broad vision for health, based on the principle of equity, an integrative strategy and operational action plans. Guidelines are available for city health planning *(84)*

and planning for health and sustainable development *(85)*. Where this is considered to be the most effective process, the coverage of the city health development plan can be checked to ensure that it includes the critical social determinants of health.

Not all cities have found it appropriate or feasible to develop this type of comprehensive policy and strategy. Some have developed sectoral or bilateral agreements, mainly with the education sector, the urban planning sector and more recently with the transport sector. Fewer cities have approached the housing and finance sectors as possible partners for tackling inequalities in health, indicating the potential scope for action in the future. Particularly following the report of the Commission on Social Determinants of Health *(2)*, some cities may still consider integrating health into specific sectoral policies to be most appropriate, but even so, the broader aims should always be clear. For example, Norway's national strategy to reduce social inequalities in health offers an example of moving towards "a combination of intersectoral efforts and short- and long-term goals relating to health determinants and designed to maintain the issue on the agenda until 2017" *(86,87)*.

Many cities have a legal responsibility for developing regular municipal plans. In Denmark and Sweden, for example, every municipality has to make a comprehensive municipal plan covering the whole municipal territory and revise it every four years. Several cities chose to tackle the social determinants of equity on health through their city development plans. This may have the advantage of linking health objectives to economic objectives and of moving towards optimizing resource allocation. For example, Helsingborg, Sweden has recently produced a Plan for Sustainable Development in Helsingborg 2010 *(88)*. This is the fifth such annual plan. It monitors progress in the previous year, gives strategic direction and provides evidence-informed information on which politicians can decide how to allocate annual budget resources.

More recently, there are examples of plans specifically to tackle the social determinants of inequalities in health, which differ somewhat from the original type I plans in that they take a more upstream approach. *Fairer Sheffield, healthy lives (89)*, for example, is an action plan on inequalities in health covering reducing poverty, creating good work, affordable housing and food and transport systems that reduce inequalities in health. Sandnes has published a standalone health development plan and has integrated this into the overall municipal development plan *(83)*. In effect, what is considered appropriate in a particular city depends largely on what will sell in the local environment.

Recent shifts in thinking at the global level, and for some cities at the EU level, could change the paradigm and encourage cities to be more ambitious in plotting the way forward.

5.8.2 The goal or vision

Whatever the approach considered appropriate in a particular city, the overall goals or visions should be made clear. For example, some years ago Göteborg, Sweden aimed for "a safe and beautiful city" and Sunderland aims to be "a prosperous city – a desirable safe and healthy place to live, work, learn and visit, where all people can reach their full potential" *(90)*. Sandnes, Norway aims to be: generous – diversity, tolerance and good communication are important; courageous – ambitious and dare to make courageous choices; healthy – well-being and the environment are important at our workplace and in developing a thriving community.

It is vital is that, based on the evidence available, cities define their vision for the future, that is, the society they hope to create, clearly indicating equity in health as their underlying value and tackling the social determinants of health as the norm. For example, the introduction to this framework gives an overall vision for Phase V.

Does your city have a clearly defined long-term vision, or mission statement, for tackling inequalities in health?

5.8.3 Formulating a policy to tackle the social determinants of health

As stated in Health21 *(49)*, "Unless there is a written policy document which can be picked up and read, discussed, and even argued over, the many partners who must be involved will not clearly understand why they should work together for health, or what their particular input might be."

Tackling the social determinants of inequalities in health covers a vast thematic area in multiple sectors and involving multiple partners. This means that multiple partners must be involved in assessing the situation and defining the objectives and priorities between them.

Perhaps the complexity of the task had not been fully understood when the Health for All policy was first developed in the early 1990s. During the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Viana do Castelo, Portugal in 2009, cities began to clarify what they must and can do during Phase V. Not all issues can be tackled during Phase V, and some, although having implications for health, may not affect inequalities in health. Ad hoc, sporadic interventions will not close the gaps, and this was again stressed during the Sandnes Conference in 2010.

In view of the inequalities in health observed in Malmö, Sweden, for example, in May 2010 a Commission for a Socially Sustainable Malmö was established. This is an independent body, headed by a well-known academic and composed of 14 commissioners with a wide spectrum of expertise in the social sciences and urban studies. Their task is to propose evidence-informed strategies for reducing inequalities in health and improving living conditions for all citizens of Malmö, and especially for the most disadvantaged people. Of particular interest is that they will also calculate the costs of inequalities in health and weigh the costs and benefits of the strategies they propose. In addition to proposing what might be done, they will also consider the governance issue such as routines for cooperation across sectors and departments.

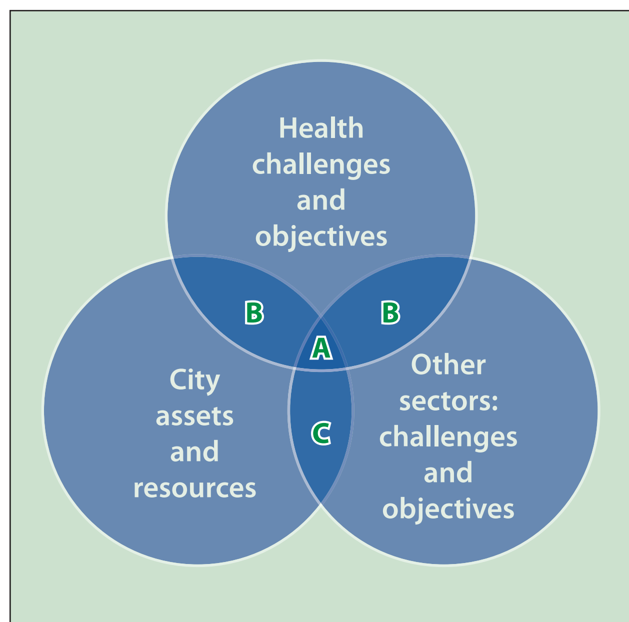
Consider establishing a commission on social determinants of health along the lines of the Malmö model, making full use of local expertise to consider the options for action.

The Commission on Social Determinants of Health report *(2)* calls for healthy places designed to promote physical and mental well-being, social cohesion and protection of the natural environment. This means that, as described in Phase V of the WHO European Healthy Cities Network, the focus must be on promoting health equity in all policies, not just through the health and welfare sectors as has hitherto been the case, and in all places within the municipal boundaries. When bilateral agreements are considered appropriate, they will be more effective if seen to be part of a longer-term vision or policy package.

In analysing the situation, as described in detail in *Twenty steps for developing a healthy cities project (91)*, due attention must be given to the whole city environment, including the national environment of which it is a part. This should also include an assessment of available assets and resources and the challenges and objectives of other sectors. In a renewed approach to tackling social determinants of inequality in health, Fig. 5 shows what is being strived for.

As this publication has stressed, creating sustainable action to tackle the social determinants of health and of inequalities in health requires being aware not only of the challenges and objectives for health but

Fig. 5. Looking for the optimum space for action



also of those in other sectors and evaluating assets to build on them, which has seldom been done. Where these intersect in the **A** section of Fig. 5 should provide optimum space for action. The **B** areas indicate the space in which it might be reasonably easy to act: areas in which the challenges and objectives are common or converging with those of other sectors or in which assets and resources offer a window of opportunity that can be easily mobilized. Area **C** provides space to think outside the box and to be more active in considering how the health sector might contribute to achieving objectives in other sectors responsible for the social determinants of health.

Epidemiological and other data indicate the main health challenges such as cardiovascular diseases or mental health. Some cities have identified specific health risks such as smoking or obesity or specific population groups such as older people as being of high priority for reducing the health gaps. Rijeka, Croatia, for example, has developed a healthy ageing strategy *(92)* focusing on many of the social determinants of inequalities in health, such as income, transport, housing, the environment and safety, access to services and social cohesion.

The report of the Commission on Social Determinants of Health *(2)* recommends action on early child development, since inequalities experienced in childhood tend to accumulate throughout the life course. Focusing on broad population groups such as children, older people or the workforce as an initial entry point could perhaps bring the highly complex process of tackling the social determinants of health within more manageable and more easily understood proportions. It should also be easier to pinpoint the champions of such groups. In developing policy on noncommmunicable diseases, for example, in which multiple risks must be tackled, some health professionals consider that developing issue-specific policies rather than general policies covering all risks is more effective. The reasons include the following.

- A single issue may be more clearly defined and understood, including links between cause and effects.
- Measures for tackling the issue may have been tried and tested.
- The number of potential stakeholders is reasonably manageable.
- Single issues are frequently supported by strong lobby groups *(23)*.

Nevertheless, several “single” issues have common root causes and health risks. In the interests of achieving greater efficiency and synergistic effects, therefore, even if more attention is given to a specific issue at a particular time, this should be in harmony with a broader approach. That is, the picture of the whole puzzle needs to be evident while smaller pieces of the puzzle are put into place.

If a broad population group is to be given particular attention, this can still be combined with a life-course and full social-gradient approach within that group. Together with general policies to improve and protect

the health of the chosen group, special attention needs to be paid to the needs of the people within that group who are in disadvantaged situations and to important steps in their life course.

Discussions and partnerships with other sectors are essential, and the health sector does not always need to take the lead. If, for example, one of the aims is to ensure that all children get a good start on the educational ladder, the education ministry or local education authorities would mainly be responsible. The health sector could, however, be concerned with discussing and supporting extra services for children in low-income families, families in which one parent is unemployed or ethnic minority families. This does not necessarily mean that the health sector would provide that extra support. It might mean that the health sector provides the information showing how poor education can affect health and how poor health can affect educational achievement, thus creating pressure for additional funding. It might mean that the health sector negotiates for better nutrition in schools or for giving mothers living in poverty the knowledge and skills to feed their children more healthily so that they can function better in school.

There may be an intention to increase tourism and, at the same time, the possibility of locally producing high-quality fruit and vegetables; combining the two could be an added attraction for tourists and encourage healthier eating. The possibilities are endless, but the first step is getting to know potential partners. The aim in getting to know such partners is to understand their objectives and to look for objectives that are common or converging.

5.8.4 Considering possible partnerships

The WHO report *Addressing the social determinants of health: the urban dimension and the role of local government (6)* develops in detail the places or sectors in which local authorities could intervene to help reduce the health gaps.

5.8.4.1 Disadvantaged areas

Disadvantaged areas are frequently devoid of green spaces, lacking in services and job opportunities and have poor housing and sometimes high crime rates. Cities in the United Kingdom have given particular attention to this mode of intervention. Care needs to be taken in defining such areas at a level small enough for inequality within disadvantaged localities to be revealed so that interactions between these and other areas can be examined. Disadvantaged areas are not always lacking in social cohesion, which is sometimes overlooked. Further, many disadvantaged people may be living in places that are well endowed.

5.8.4.2 Education

Education is clearly a primary influence on health. In some countries, local authorities are not responsible for basic education services, but they may be responsible for the buildings and can affect the surrounding environment of educational establishments. This could, for example, include ensuring the possibility of children walking or cycling safely to school, ensuring adequate space for physical activity and promoting opportunities for a healthy diet. City authorities can also use their leadership to create broader partnerships for health and stronger interaction between schools and the community.

5.8.4.3 Urban design and the movement of people and goods

The needs to tackle the social determinants of health and to reduce global warming are closely intertwined. Local authorities have a leading role in facilitating the active movement of people of all ages during their everyday activities and in reducing the use of private cars, by promoting: walking, cycling, the use of public transport, the use of stairs rather than elevators and the free movement of wheelchairs, babies' prams and shopping carts. People with no car need easy access to services and recreational areas. This is partly an issue

of urban design. As has been said elsewhere, it is unreasonable to expect people to change behaviour when the environment discourages change. When the local environment becomes walkable, this can have wider implications than simply encouraging physical activity, as people who walk around their area are more likely to know their neighbours and to be socially engaged. It can also be an issue of city regulations. Research shows that more people are killed on the roads in areas with low income than in areas with high income and that lower speed limits save lives. The cost of using swimming and athletic facilities can be an obstacle to physical activity for low-income groups.

5.8.4.4 Fair employment and health at work

Research shows that having a good job protects health and that unemployment and insecure employment can harm health. Cities can lead by example by ensuring that municipal employees have as far as possible, security of employment, remuneration that ensures a decent standard of living, safety at work and as much control over their working environment as possible. As part of their effort to tackle inequality, in June 2010 the London Assembly committed over the long term to gradually reduce the difference in pay between the personnel with the lowest and highest salaries to no more than 10 times. Cities can act as role models for health-promoting workplaces. Working conditions in health and social services leave much to be desired in some cities, especially those of women with low salaries.

Attracting job opportunities to the city will not only improve economic and social development but also help reduce the health gaps. Support for small businesses through financial packages in collaboration with national development agencies (and EU regional development programmes) moves in this direction, as are efforts by municipalities to buy locally.

Close collaboration with and support to local employers to improve working conditions can have similar multifaceted benefits. This includes tackling the six work stressors: demands, control, support, relationships, role and change *(2)*. This is increasingly important in the present economic situation. Many cities are also enhancing people's capacity for employment through skill development and retraining courses. In Denmark, for example, continuing vocational training services for both employed and unemployed people have been in place for many years. Supported by government funding, these services not only give workers greater mobility in the labour market but are regarded as a subsidy to the competitiveness of Danish industry *(2)*.

This is also one of the win-win situations in which health objectives converge with those of other sectors. In 2004 for example, William Bird *(93)* estimated that the National Health Service in the United Kingdom could save considerable money through reduced demands for care, and local economies could benefit, mainly through reduced absence from work and reducing the risk of early mortality.

5.8.4.5 Housing

There are well-defined links between poor housing and poor health. Improvements that reduce exposure to specific hazards both improve the health of current inhabitants and prevent harmful exposure to future generations.

The most serious hazards relate to poor air quality, inadequate heat and dampness, radon, noise and fire, and in some cities inadequate protection from high or low ambient temperatures. Poisoning, falls and fires in the home are preventable causes of death and injury, especially among children and older people. Improved housing is consistently reported to improve mental health. Cities providing social housing can intervene directly at this level but also can work with local landlords to ensure better conditions, especially in housing in disadvantaged areas and where migrants congregate.

5.8.4.6 Access to healthy nutrition

Obesity is a serious challenge facing the European Region and disproportionately affects disadvantaged groups. Changes in eating patterns cannot be easily achieved if, for example, fruit and vegetables are not easily and cheaply available. Greenwich has found one way of tackling this: mobile fresh fruit and vegetable stalls that visit areas without local shops.

In addition to providing inexpensive healthy food, residents have reported that this has encouraged them to start talking to their neighbours – which then makes them feel safer and better about their neighbourhood *(94)*.

5.8.4.7 Social services

Social services already collaborate with the health sector in most cities. Given the existing links and staff qualifications, this also has tremendous potential for shifting from the traditional client–professional relationship to one of engaging with local people and public, private and voluntary activities for developing services to meet people's needs as they see them and building on their own strengths.

5.8.4.8 Environment

Healthy urban development and design is one of the core themes for Phase V of the WHO European Healthy Cities Network. The local level can play a decisive role in protecting the natural environment and improving the built environment to enhance healthy lifestyles, encourage cycling and walking as part of daily activities and create opportunities for social interaction. In this time of economic recession, not all such interventions need to be expensive and can enhance the city as a place to live, work and visit. Some cities still need to ensure clean drinking-water and safeguard local swimming areas. Efficient waste and garbage disposal and procedures for recycling have important effects on health, global warming and the overall environment in cities.

5.8.4.9 Urban green space

Although it is linked to the environment, urban green space is dealt with separately because its importance is increasingly recognized. Public parks, which can be expensive to create and maintain, are only a small part of urban green space.

Green spaces provide opportunities for physical activity and social networking; improve mental health *(95)*, including enhancing worker productivity and self-esteem; can relieve anxiety and depression and boost immunity; promote healing after an accident or illness; and can mitigate climate change *(96)*. Trees can be planted in residential areas around schools, kindergartens and playgrounds, especially in disadvantaged areas. Even potted plants can be beneficial. Research has shown, for example, that sowing wildflowers, which take care of themselves, can improve mental health.

5.8.5 Setting goals, objectives and targets

Many of the actions to reduce the health gaps do not produce short-term results and require perseverance over a longer period that the term of a city council. It is therefore important to set both long and medium-term goals and objectives and possible quick wins for reducing the gaps. Since this requires the collaboration of several sectors, the objectives should be sufficiently clear to ensure that the various stakeholders perceive them similarly.

The most common criteria for selecting objectives are *(15)*:

- the extent to which a health problem is a major cause of mortality or morbidity;
- whether solving the problem could reduce the health gaps;
- the scope for improvement through interventions that have been shown to be effective and are politically acceptable;
- public and professional opinions on whether the health problem is a major concern;

- whether there are reliable indicators to measure progress towards achieving the objective or target and whether data for measuring progress are available or can be easily collected; and
- constraints, including cost constraints.

As an asset-based approach is strived towards, available assets should be added to the list of criteria.

Determining the priorities between these objectives is equally important. Evidence indicates that the lack of priority-setting at both the national and city levels has frequently been a serious obstacle to progress.

Some countries and cities have been deterred from setting quantitative targets for several reasons *(15)*:

- the difficulty in providing scientifically credible evidence for some targets;
- the reluctance of politicians and health professionals to set targets for which they will be held accountable, especially if the targets are in areas over which they have little or no influence; and
- the danger of appearing to give priority to issues for which targets can be easily quantified when other issues that are less easy to quantify might be considered equally or more important.

Nevertheless, as Health21 *(90)* clearly stated, setting targets has advantages.

- The process of setting targets requires assessing the present situation and expected future trends as scientifically as possible.
- Monitoring the targets offers an excellent learning experience through discussion of what had been hoped for, the extent to which this was achieved and why.
- Targets provide a powerful communication tool.
- Targets indicate to potential partners what must happen and what their role might be in making this happen.
- Targets can provide a rallying call for groups at the grassroots level to demand action.
- Targets can be an excellent tool for strengthening accountability for health (which is one reason why some groups would like to avoid them).
- Certain targets can provide a reference point for assessing the advisability of day-to-day action.
- Involving people in the process of setting targets raises awareness and can be the first step in implementing health policy.

Following the logical framework approach, several countries widely accept that targets should be specific, measurable, achievable, realistic and time-bound (SMART) *(97,98)*.

On the global level, the setting of the Millennium Development Goals, which are quantitative targets, may have influenced the target-setting process in countries. In recent years, an increasing number of countries and cities are setting targets for health.

The type of targets being set range from outcome targets that relate to changes in the health status of certain groups, intermediate targets related to changes in the distribution of health risks or in the distribution of power, money and resources and process targets relating to necessary administrative or structural changes.

Past experience shows that, at both the city and national levels, there can be a failure to agree and put in place the process and indicators for monitoring and evaluating progress. Particularly in the case of changes in the social determinants of health, which are frequently long term, monitoring the links along the pathway from intervention to intermediate or final outcomes is essential to revealing possible obstacles or needs for adjustment.

5.8.6 Process of formulating policy

Stakeholders must be involved from the beginning of the process of developing policy to achieve the strong ownership essential for implementing action across sectors. Some cities have included action plans in the policy documents themselves; others prefer to follow

up with annual action plans, for example. What is vital is that action plans clearly indicate what needs to be done, how it is to be done, by whom, when, where and with what resources.

Include as broad a range as possible of stakeholders in the process of formulating policy.

Clearly define objectives and the priorities between them.

Ensure that action plans clarify what is to be done, when and by whom and the resources necessary to do this.

Assign responsibility for monitoring progress in the process of implementing policies to tackle the social determinants of health, whether comprehensive policies on the social determinants of health, bilateral policies or action included in the plans of other sectors and departments.

Set up processes for evaluating the effectiveness of key actions and interventions.

The city health department must be available as a source of information and support to intersectoral partners. This is especially important if health impact assessment, for which expertise needs to be built up, is part of the policy package.

Unless the necessary financial resources, human resources including staff time and other resources such as capacity-building are in place, and the necessary administrative, organizational or structural changes are made, the policies on the social determinants of health may remain as a book on the shelf.

Cities are already testing possibilities for securing resources such as designating certain local taxes for specific purposes or including equity criteria when assessing funding requests from various sectors.

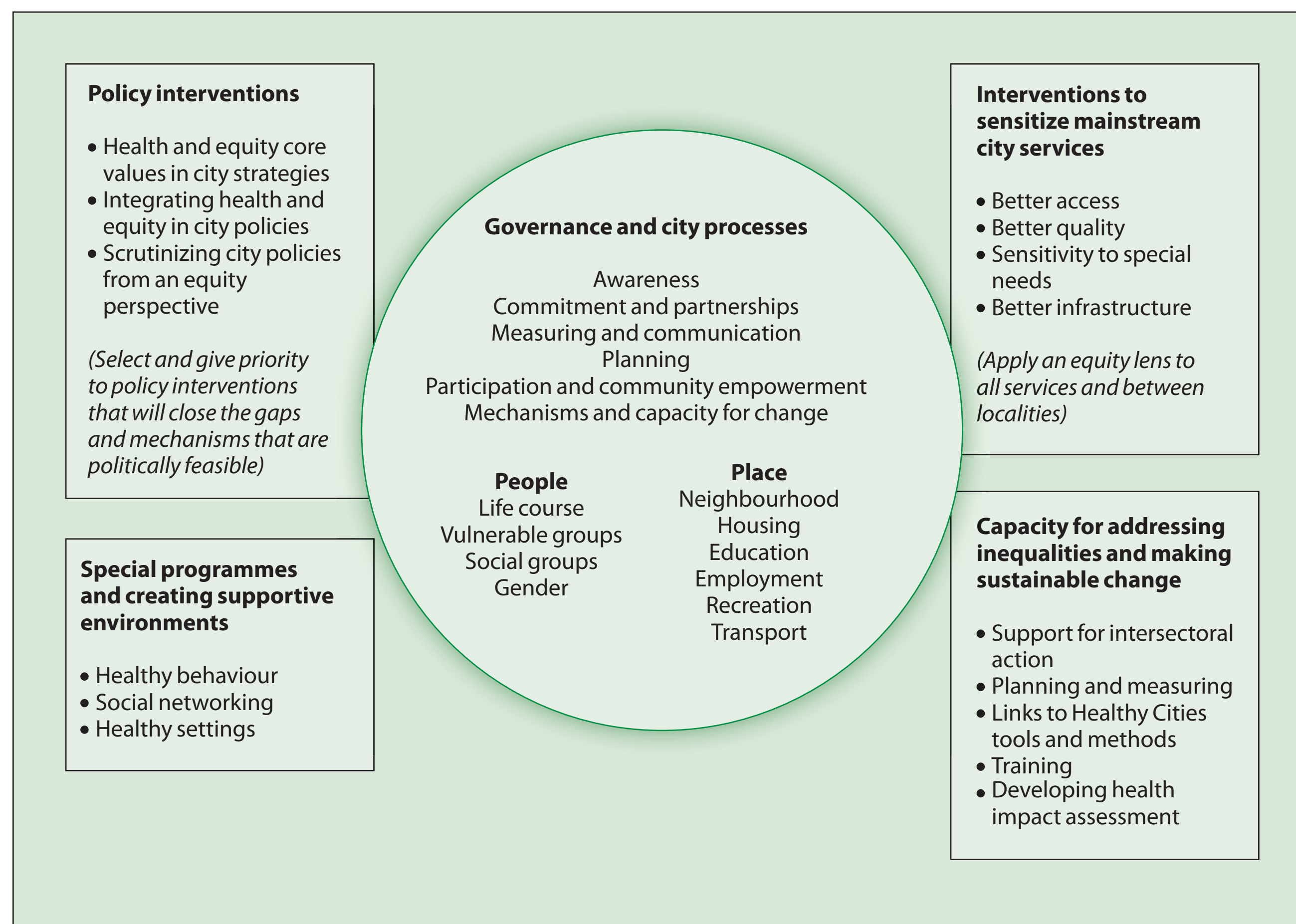
Agreement on the means of monitoring and evaluation should be clarified when formulating policy formulation and the resources and capacity for doing this should be put in place.

6. Moving to action – bringing it all together

The health gaps cannot be closed during the next four years, but a sustainable process can be established to help prevent further widening of the gaps and perhaps to help to level out the social gradient somewhat. The issues of concern are discussed above in some detail (Fig. 6).

In this concluding section, readers are also reminded of the main self-assessment questions posed throughout the text. These have been grouped to facilitate cities in selecting their immediate and longer-term action points, depending on their present local situation.

Fig. 6. City action points



Source: Geoff Green, Professor, Sheffield Hallam University, United Kingdom.

6.1 Governance and processes

At the centre of Fig. 6 are the prerequisites for tackling the social determinants of inequalities in health. First and foremost is an awareness of the inequalities in health and commitment to tackle them. This is closely linked to the top left-hand rectangle, which is concerned with ensuring that all city strategies reflect the principle of the equity in health, that the potential effects of all city policies on equity in health are assessed and that policies to close the gaps are given priority.

The relevant questions to be asked are:

Is the definition of inequality in health and its causes readily available in your national language in a form that is easily accessible and understood?

Is there an easily accessible explanation of the social determinants of health and the implications for city development if no attempt is made to ensure that they are more fairly distributed (such as on the city web site, a short handout or slide presentation)?

Has relevant WHO material been translated in your national language, or are similar national documents available?

This material should be available for prospective partners throughout public administration, for all types of associations (including trade unions, associations of private enterprise and other nongovernmental organizations) and for the general public through schools, workplaces and places of recreation. Two or three years down the line, a significant proportion of the city decision-makers and the population should understand the importance of tackling the social determinants of inequality in health.

All cities participating in Phase V of the WHO European Healthy Cities Network are committed at the highest political level to tackling inequality in health. The essential whole-of-city-government accountability and responsibility for promoting equity in health will only be achieved, however, when the following questions are answered positively.

What efforts have been made ensure that the complex issue of equity in health and its policy implications are widely understood, such as face-to-face meetings, workshops and the mass media?

Does your city's vision for the future refer at least implicitly to a society in which everyone can reach his or her full health potential?

Do all relevant city policy documents clearly define the principle of equity in health and not only those related directly to the health sector?

Have you investigated ways of involving all political parties in the city council to commit themselves to tackling inequality in health?

Do you report regularly to the city council on trends in inequality in health, such as through issue-specific reports and/or in background documents to the annual budget?

Commitment 1. By 2013, the entire city administration and the local media should broadly understand the concept of equity in health and its social determinants.

Linked to all four rectangles of Fig. 6 is the need to apply an equity lens to:

- city localities;
- policy interventions:
- providing mainstream services: and
- creating supportive environments.

In some cases, this requires no more than an equity impact culture, so that decision-makers take into account how their actions may affect the social determinants of health. In other cases, more formal health impact assessment may be needed.

Is a system in place for screening policies in key sectors, emphasizing how they may affect the health of population groups at higher risk?

Have capacity-building health impact assessment courses been established for politicians and decision-makers so that they regularly apply an equity lens?

Are training courses in place for those who will actually carry out health impact assessment?

The central section of Fig. 6 refers to what have perhaps proved to be among the most difficult challenges in tackling the social determinants of health: developing sustainable partnerships across sectors and the mechanisms and capacity for change, including broader participation and community empowerment.

What structures and processes for working across sectors are already in operation in your city?

Are they effective in encouraging joint planning, joint funding or at least mutual exchange of information and experience?

Could tackling the social determinants of health be introduced into such successfully operating processes?

Should new processes and structures be set up, and how can these be given high visibility and support?

6.2 Improving the knowledge base for tackling the social determinants of health

Improved information and knowledge is essential for all segments of Fig. 6, so that cities have the capacity:

- to define the main health challenges and their causes;
- to assess possible assets and ways of tackling the health gaps;
- to monitor progress in closing the gaps; and
- to evaluate the effectiveness of interventions.

Given the renewed focus on working across sectors, potential partners need to be engaged from the initial compilation and analysis of information:

- to avoid possible duplication in compiling data;
- to ensure that all sources of reliable information across sectors are fully used;
- to involve the expertise available in local universities and research centres;
- to improve the comparability of information within the country and internationally; and
- to gain greater understanding from local people as to the challenges they face and how they believe existing challenges might be tackled and emerging challenges minimized.

Commitment 2. By 2012, all cities should have available an analysis of inequalities in health in their city and their causes as the result of a judicious use of available information and considered opinion.

Each city will select the approach most appropriate to the present level of development of its evidence base. Relevant questions include the following.

Have you prepared a city health profile? If so, can this be considered reasonably up to date?

Does the city health profile or a similar report cover the main social determinants of inequality in health?

Did the process of formulating this report include as wide a range of stakeholders as possible?

Has an assessment been made of reliable data sources available in the city, both within the health sector and other sectors, in academic centres and in the private sector?

6.3 People and places

Based on the evidence available, including informed opinion, cities should be able to highlight serious chal-

lenges in terms of the incidence of disease and disability, the prevalence of lifestyles and behaviour that put health at risk, the situation in relation to the social determinants of health and how all of these are distributed in socioeconomic groups of the population.

Are ways being considered to fill possible gaps? Could socioeconomic variables be linked to regularly collected data?

Are academic or other institutions in your city engaged in related research or could they be encouraged to do so?

Have you considered the possibility of establishing an independent commission on the social determinants of health to fully use local expertise in considering the challenges and options for tackling the social determinants of health?

Have you investigated developing an asset-based method within the specific culture of your city?

Even when detailed information is not available, local knowledge will be sufficient to pinpoint the localities in which the level of the social determinants of health (such as housing, education, employment, transport, recreation and neighbourhood facilities) is comparatively poor. There is already sufficient research to indicate that tackling such inequality can help close the health gaps *(99)*.

What are the main health challenges in your city faces?

Which population groups do you consider to be particularly vulnerable in your city: inhabitants of particular neighbourhoods, long-term unemployed people, people employed in high-risk occupations, children living in poverty, migrants, Roma?

Where is the greatest inequality in the social determinants of health: disadvantaged neighbourhoods, access to certain services, access to employment etc.?

Making tackling the social determinants of health a whole-of-city-government process requires being aware of possible assets in assessing people and places. These could include many factors such as: natural physical assets, a high level of urban planning and infrastructure, a strong labour force, skilled retirees, academic institutions, important private enterprises, strong nongovernmental organizations, neighbourhood networks and charismatic leaders in any sector. The asset-based approach suggests mapping out the assets of individuals, associations and institutions.

6.4 Mapping the way forward

As discussed above, tackling the social determinants of health is a broad and complex issue and could be overwhelming if the priorities and guidelines are not clear. Tackling the social determinants of health and inequality in health is also a long-term process. It is essential therefore that both long- and medium-term objectives be defined after the main risks to equity in health and the possible assets to be mobilized are highlighted.

The priorities between objectives should show clearly what is to be tackled first, where the main responsibility for taking action lies and with what resources. In this way, each small action can be slotted into the appropriate place, leading to long-term goals. For example, Sheffield's action plan *(88)* clearly defines objectives, actions, milestones, expected outcomes, time scales and responsibility and defines a basket of indicators of inequality in health to monitor progress.

Criteria used to select priorities could include:

- extent of the problem:
  - as a major cause of inequality in mortality or morbidity;
  - differences in behaviour that put health at risk;
  - unequal distribution of the social determinants of health;

- public and professional opinion on whether the issue is of major concern;
- scope for improvement through effective and acceptable interventions:
- political acceptability and feasibility of taking action;
- position and attitude of major stakeholders in sectors or settings in which interventions need to be made; and
- potential for overcoming constraints, offering acceptable trade-offs and mobilizing assets.

Having defined their overall long-term vision, cities may opt to concentrate on the full life course, such as in Ireland's National Action Plan for Social Inclusion 2007–2016 *(100)*, to focus on early childhood as recommended by the Commission on Social Determinants of Health *(2)*, or if, for example, overall demographics or development objectives indicate this, to give priority to people of working age or older people. For example, a workshop of key decision-makers in November 2008 to initiate Phase V in Belfast gave priority to the health of children *(101)*.

As seen above, concentrating only on the most vulnerable people is not sufficient; certain groups will be selected for more intensive action. Regardless of the criteria for selecting these groups, multifaceted action will be more effective than single projects or programmes. This means considering all four quadrants of Fig. 6. It also means taking advantage of possible subnational, national or even European Region action. Finally, it should include a new approach to working with local residents as part of the solution.

Commitment 3. By 2013, the following should be clear in all cities: the main objectives and targets related to equity in health and the social determinants of health, how these will be achieved, who is responsible for taking action and how progress will be monitored and evaluated.

7. How WHO and the WHO European Healthy Cities Network could help

During the Annual Business and Technical Conference of the WHO European Healthy Cities Network and Network of European National Healthy Cities Networks in Sandnes, Norway in 2010, participants offered valuable advice on how WHO and the WHO European Healthy Cities Network could support cities in tackling the social determinants of inequalities in health. These included the following.

- Participants suggested revising the draft of this publication to include more examples of work being carried out in cities. This has been done.
- A brief document or pamphlet and perhaps a slide presentation should be prepared to explain the issue of tackling social determinants of inequalities in health.
- A buddy system should be established to facilitate exchange of experience between cities and rapid response to queries and requests for advice. This could be as simple as providing the names and contacts of people in the WHO European Healthy Cities Network who are working specifically on the social determinants of health or could amount to a more formal twinning of cities for mutual support.
- Examples of city experiences should be compiled and made available to cities.
- Peer reviews should be organized so that cities can take advantage of the opportunity to bring in peers for in-depth discussion in a non-threatening environment, with the ultimate aim of sharing this experience in the wider network. For cities in EU countries, it is worth noting that consideration is being given to funding peer reviews under the EU PROGRESS employment and social solidarity programme.
- Examples of specific tools should be compiled, such as health impact assessment screening tools.
- The experience in a selected number of cities should be analysed comparatively.

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Healthy cities tackle the social determinants of inequities in health: a framework for action

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